

Washington State – Integrated Community Mental Health Program

Section D. Cost Effectiveness

In order to demonstrate cost effectiveness, a waiver renewal request must demonstrate that it was cost-effective during the previous two-year waiver period (Years 1 and 2) and must show that the cost of the waiver program will not exceed what Medicaid costs would have been in the absence of the waiver in the upcoming two-year waiver period (Years 3 and 4).

With respect to waivers involving capitated reimbursement, a State's computation of its UPL (as required by 42 CFR 447.361) may serve the dual purpose of computing the projected Medicaid costs in the absence of the waiver as well. **The UPL is only one component of waiver cost effectiveness, which must also include comparisons of a State's administrative costs and relevant FFS costs with and without the waiver as well.**

HCFA offers the following suggestions to States in completing this section:

- States are strongly encouraged to use the revised waiver preprint format to reduce the number of questions regarding their cost-effectiveness calculations. Please note that use of the revised preprint is optional.
- Cost effectiveness for 1915(b) waivers is measured in total computable dollars (Federal and State share).
- States are not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations for services. States should have Per Member Per Month (PMPM) costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18 of Appendix D.IV of their initial preprint. **Please ensure that you are using the PMPM Without Waiver costs that were approved in the previous waiver in your renewal.** In addition, States will also not be held accountable for benefit package, payment rate, or other programmatic changes made to the waiver program.
- Waiver expenditures should be reported on the Quarterly Medicaid Statement of Expenditures (Form HCFA-64 Report), according to reporting instructions in the State Medicaid Manual, Section 2500. If the State has specific questions regarding this requirement, please contact your State's HCFA accountant in the Regional Office.
- A set of sample preprint Appendices has been included with this preprint using Year 2 of one State's experience (DSAMPLE.XLS). Blank Appendices have been included for your use (APPD.XLS). **Please modify the spreadsheets to meet your State's UPL and rate development techniques, using the State's capitated rate cells (most states use eligibility category, age, and gender-adjusted cells).** If a waiver program does not cover all categories of service, the State should modify the

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spreadsheet to include only covered services. Please submit the electronic spreadsheets used to create the Appendices to HCFA (HCFA currently uses Excel, which will convert both Lotus and QuatroPro). Please structure the worksheets as schedules which can link the totals between spreadsheets and roll up into a summary if the State has that capability. Linking the sheets and summaries will reduce copying from one schedule to another, which may introduce errors.

- The costs and enrollment numbers for voluntary populations (i.e., populations which can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in the waiver. In general, HCFA believes that voluntary populations should not be included in 1915(b) waivers (i.e., excluded in Section A.II.l and A.II.m). If the State wants to include voluntary populations in the waiver (i.e., listed in Section A.III.b.3), then the costs and enrollment numbers for the population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in the waiver are required to submit a written explanation of how selection bias will be addressed in the rate setting or with waiver calculations. HCFA may require the State to adjust its upper payment limits for the voluntary population to account for selection bias.

Description of the Cost-Effectiveness Calculation Process:

In general, the UPL for capitation contracts on a risk basis (e.g., MCO, HIO, or *PHP*) is the State agency's estimated cost of providing the scope of services covered by the capitation payment if these services were provided on a FFS basis. Documentation for the without waiver costs must be calculated on a per member per month basis.

- In order to determine cost-effectiveness, States must first document the number of member months participating in the waiver program for the previous waiver period (Year 1 and Year 2). They must then estimate the number of member months for the target population which will participate in the waiver program for the upcoming waiver period (Year 3 and Year 4) See Appendix D.II, Steps 1-4. The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in Year 1 and Year 2.
- The base year and the source of the without waiver data need to be identified for Years 1 - 4. The sources for this data and any adjustments to this data must be listed (Appendix D.III, Steps 5-9). If the State is proposing to use a different methodology for Years 3 and 4, please document all differences between the methodologies. Without Waiver Costs should be created using a FFS UPL based on FFS data with FFS utilization and FFS inflation assumptions. HCFA recommends that a State use at least three years of FFS Medicaid historical data to develop utilization and inflation trend rates.
- Statistically valid (as defined by the State's actuary) without waiver cost and

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eligibility data for the population to be covered must be established. Base years should be specific to the eligibility group and locality covered by the contract and, to the extent possible, the costs included in the capitation rates. The exception to this would be where the size of the group is not sufficiently large to represent a statistically valid sample. These base year costs need to be broken down into each of the main service categories covered under the contract—inpatient hospital, outpatient hospital, physician, lab and x-ray, pharmacy, and other costs (Appendix D.IV, Steps 10-13).

- Once the base year costs are established, States need to make adjustments to that data in order to update it to the year to be covered by the capitation contract. These adjustments represent the impact on Medicaid costs from such things as inflation, utilization factors, administrative expenses, program changes, reinsurance or stop-loss limits, and third party liability. When these adjustments are computed and factored into the base year costs, the end result is a projected UPL for the year under contract (Appendix D.IV, Steps 14-16). The State then needs to consider the effect of costs which are outside the capitation rate (and therefore outside the UPL), but are affected by the capitated contractor. These services are generally referred to as wraparound services, and may include such services as pharmacy. Because the capitated contractor can affect the costs of these wraparound services, they must be included in the without waiver cost development (Appendix D.IV, Steps 17-18). Without waiver costs must be developed for all Years 1 - 4.
- States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. The costs should include services controlled by the waiver but not in the capitated rate, plus the agency's average per capita administrative costs related to these services (Appendix D.V, Steps 19-29).
- States must then calculate the aggregate costs without the waiver and the aggregate costs with the waiver (Appendices D.VI, D.VII, Steps 30-35).
- States must clearly demonstrate that, when compared, payments to the contractor did not exceed the UPL in the past two years and will not exceed the UPL in the future two years (Appendix D.VIII, Steps 36-37), and costs under the waiver did not exceed costs without the waiver costs in the previous period and will not exceed without waiver costs in the future (Appendix D.VIII, Steps 38-40).

Assurance (Please initial or check)

 x The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Medicaid Financial Officer: Susan Lucas

Washington State – Integrated Community Mental Health Program

Telephone Number: (360) 902-0830

The following questions are to be completed in conjunction with the Worksheet Appendices. We have incorporated step-by-step instructions directly into the worksheet using instruction boxes. Where further clarification was needed, we have included additional information in the preprint. All narrative explanations should be included in the preprint.

I. Type of Contract The response to this question should be the same as in A.II.e.

- a. Risk-comprehensive (fully-capitated--MCOs, HIOs, or certain *PHPs*)
- b. x Other risk (partially-capitated--*PHP*)
- c. Non-risk. Please use Section C of the PCCM initial application.
- d. Other (please explain):

II. Member Months: Appendix D.II.

Purpose: To provide data on actual and projected enrollment during the waiver period. Actual enrollment data for the previous waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed to determine whether the waiver is likely to be cost effective. This data is also useful in assessing future enrollment changes in the waiver.

Step 1: Please list the rate cells which were used in setting capitation rates under the waiver. The number and distribution of rate cells will vary by State. If the State used different cells in Years 1 & 2 than in Years 3 & 4, please create separate tables for the two waiver periods. The base year should be the same as the FFS data used to create the PMPM without waiver costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted here. Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Step 2: See instruction box. If the State estimates that all eligible individuals will not be enrolled in managed care (i.e., a percentage of individuals will be unenrolled because of eligibility changes and the length of the enrollment process) please note the adjustment here.

Step 3: See instruction box. In the space provided below, please explain any variance in member months, by region, from Year 1 to Year 4.

Step 4: See instruction box. In the space provided below, please explain any variance in total member months from Year 1 to Year 4.

- a. Population in base year data

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1. x Base year data is from the same population as to be included in the waiver.
2. Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation which supports the conclusion that the populations are comparable.)

III. Without Waiver Data Sources and Adjustments: Appendix D.III.

Purpose: To explain the data sources and reimbursement methodology for base year costs.

To identify adjustments which must be made to base year costs in order to arrive at the UPL for capitated services and the without waiver costs for all waiver services.

NOTE: The data on this schedule will be used in preparing **Appendix D.IV Without Waiver Cost Development**. Also, it is acceptable to use encounter data or managed care experience to develop with waiver costs or set capitated rates (see Section D.V). At this time, it is not acceptable to use experience data to develop without waiver costs. A workgroup has been formed to examine this policy. This submittal will be updated based upon the outcome of that workgroup.

NOTE: If the State is proposing to use a different methodology for Years 3 and 4 than were used in Years 1 and 2, please document all differences between the methodologies.

Regional Offices approve annual UPLs and contract rates developed by States. They are authorized to approve UPLs and contract rates that fall under the methodologies granted under the original and subsequent waiver authority. Modifications to the UPL development methodology should be approved through a waiver modification as explained in the instructions to this submittal.

Step 5: Actual cost and eligibility data are required for base year PMPM computations. Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. **Please note the waiver years that this methodology was in place. Submit separate Appendix D.III charts if different methodologies or services were used in the Without Waiver costs for the upcoming waiver period than in the previous waiver period.** Please provide an explanation in the space below if: a) multiple years are used as the base year; or b) data from sources other than the State's MMIS are used.

Step 6: See instruction box. This chart should be identical to the chart in Section A.III.d.1.

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Step 7: UPL Adjustments: On Appendix D.III check all adjustments that apply to base year data.

Step 8. Fee-For-Service Wraparound Cost Adjustments: See instruction box.

Instructions For Steps 7 and 8 above:

Required Adjustments a. through g. (below) and Appendix D.III must be completed by all States. Optional Adjustments a. through i. (below) should be completed if the adjustment applies to your State. For each Optional Adjustment that does not apply, the State should note if they have made a policy decision to not include that adjustment. If the State has made an adjustment to its without waiver cost, information on the basis and methodology information below must be completed and mathematically accounted for in Appendix D.IV. All adjustments may be computed on a statewide basis, although some (e.g. reinsurance, stop/loss) may be specific to certain contracts and should be noted where appropriate. Similarly, some adjustments will apply to all services and to all eligibility categories while others will only apply to specific services provided to distinct eligibility categories. Again, it is very important to complete this preprint and Appendices D.III and D.IV as necessary to account for the proper methodology used by the State to calculate the UPL.

Describe below the methodology used to develop each adjustment. Prior approval is necessary for methodologies that are not listed as an optional check-off. Please note on each adjustment if the methodology is proprietary to the actuary. Note: HCFA's intent is that if an accepted methodology is used (i.e., is one of the check-offs) and the size of the adjustment is noted in the Appendices and appears reasonable, then no additional documentation would be required for the waiver application. However, the HCFA RO may require more documentation during the UPL and contract rate approval process.

Please note the waiver years that each adjustment was in place if the adjustment was not made for all four years. Submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Previous Waiver Period

a. _____ During the last waiver period, the methodology used to calculate cost-effectiveness was different than described in the waiver governing that period. The differences were:

Please note the date of any methodology change and explain any methodology changes in this preprint. See also Step 5.

Upcoming Waiver Period -- For all three subsets of adjustments (Without Waiver Response required, Optional, and With Waiver Cost Adjustments) in this section,

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please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

State Response to These Adjustments Is Required

a. Disproportionate Share Hospital (DSH) Payments: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PHPs. Therefore, DSH payments are not to be included in cost-effectiveness calculations. Section 4721(c) does permit an exemption to the direct DSH payment.

If this exemption applies to the State, please identify and describe in the Other Block.

1. x We assure HCFA that DSH payments are excluded from base year data.
2. x We assure HCFA that DSH payments are excluded from adjustments.
3. Other (please describe):

b. Incurred but not Reported (IBNR) (Appendix D.III, Line 47): Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.

Basis:

1. x IBNR adjustment was made. Please indicate the number of years used as basis 3+years
 - i. x Claims in base year data source are based on date of service.
 - ii. Claims in base year data source are based on date of payment.

2. IBNR adjustment was not necessary (Please explain).

Methodology:

1. x Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.
2. Other (please describe):

c. Inflation (Appendix D.III, Line 48): This adjustment reflects the expected inflation in the FFS program between the Base Year and Year One and Two of the waiver. Inflation adjustments may be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.

Basis:

1. State historical inflation rates
 - (a) Please indicate the years on which the rates are based: Inflation base years
 - (b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

2. x Other (please describe): *Bureau of Labor Statistics inflation factor for*

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medical inflation

d. Third Party Liability(TPL) (Appendix D.III, Line 61): This adjustment should be used only if the State will not collect and keep TPL payments for post-pay recoveries. If the MCO/PHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and methodology

1. ☐ No adjustment was necessary
2. ☒ Medicaid Management Information System (MMIS) claims tapes for UPL and rate development were cut with post-pay recoveries already deducted from the database.
3. ☐ State collects TPL on behalf of MCO/PHP enrollees
4. ☐ The State made this adjustment:
5. ☐ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PHPs.
6. ☐ Other (please describe):

e. FQHC and RHC Cost-Settlement Adjustment (Appendix D.III, Line 46) : This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO/PHP to an FQHC or RHC and the reasonable costs of the FQHC or RHC. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

1. ☐ Cost-settlement supplemental payments made to FQHCs/RHCs are included in without waiver costs, but not included in the MCO/PHP rates, base year UPL costs, or adjustments. The State also accounted for any phase-down in FQHC/RHC payments beginning in Fiscal Year 2000, as outlined by Section 4712 of the BBA. If the State pays a percentage of cost-settlement different than outlined in the BBA not to exceed 100 percent, please list the percentage paid . The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

2. ☒ Other (please describe): No settlement payments in without waiver costs or in rates.

f. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 51): Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the UPL.

1. ☐ Payments outside of the MMIS were made. Those payments include (please describe):

2. ☐ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3. ☒ The State had no recoupments/payments outside of the MMIS.

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g. Pharmacy Rebate Factor (Appendix D.III, Line 68): Rebates that States receive from drug manufacturers should be deducted from UPL base year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated UPL may result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are under the waiver but not capitated.

Basis and Methodology:

1. _____ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.

2. x The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3. _____ Other (please describe):

Optional Adjustments

Note: These adjustments may be made based upon the State's own policy preferences. There is no HCFA preference for any of these adjustments. If the State has made an adjustment to its without waiver cost, information on the basis and methodology used is required and must be mathematically accounted for in Appendix D.IV. If the State has chosen not to make these adjustments, please mark the appropriate box.

a. Administrative Cost Calculation (Appendix D.III, Line 44): The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO/PHP if these members had been enrolled in FFS.

Only those costs for which the State is no longer responsible should be recognized. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.

Basis:

1. x All estimated administrative costs of the FFS plan that would be associated with enrolled managed care members if they had been enrolled in the FFS delivery system in this adjustment. This is equal to 5 percent of FFS service costs.

2. _____ The State has chosen not to make adjustment.

3. _____ Other (please describe):

Methodology:

1. x Determine administrative costs on a PMPM basis by adding all FFS administrative costs and dividing by number of total Medicaid FFS members

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2. _____ Determine the percentage of medical costs that are administrative and apply this percentage to each rate cell.

3. _____ Other (please describe):

b. Copayment Adjustment (Appendix D.III, Line 45): This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these copayments are included in the UPL if not to be collected in the capitated program.

Basis and Methodology:

1. _____ Claims data used for UPL development already included copayments and no adjustment was necessary.

2. _____ State added estimated amounts of copayments for these services in FFS that were not in the capitated program.

3. x The State has chosen not to make adjustment.

4. _____ Other (please describe):

c. Data Smoothing Calculations for Predictability (Appendix D.III, Line 65): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.

Basis and Methodology

1. _____ The State made this adjustment (please describe):

2. x The State has chosen not to make adjustment.

d. Investment Income Factor (Appendix D.III, Line 50): This factor adjusts capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time of services.

1. _____ Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the UPL was made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are provided.

2. x The State has chosen not to make adjustment.

3. _____ Other (please describe):

e. PCCM case-management fee deduction (Appendix D.III, Line 52): When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL.

1. _____ PCCM claims data were used to create capitated UPLs and management fees were deducted. Please note: if the State chose to use PCCM claims data, then this adjustment is required.

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2. ☒ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.

3. _____ Other (please describe):

f. Pooling for Catastrophic Claims (Appendix D.III, Line 53): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.

Methodology:

1. _____ The high cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of capitation payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization.

2. ☒ The State has chosen not to make adjustment.

3. _____ Other (please describe):

g. Pricing (Appendix D.III, Line 54): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1. _____ Expected State Medicaid FFS fee schedule increases between the base and rate periods.

2. ☒ The State has chosen not to make FFS price increases in the managed care rates.

3. _____ Changes brought about by legal action (please describe):

4. _____ Changes in legislation (please describe):

5. _____ Other (please describe):

h. Programmatic/policy changes (Appendix D.III, Line 55): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the UPL. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.

Basis and Methodology:

1. ☒ The State made this adjustment (please describe). Related to inpatient rate rebasing for DRG claims.

2. _____ The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

i. Regional Factors applied to Small Populations (Appendix D.III, Line 59): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.

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Methodology:

1. _____ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smooths out wide fluctuations in individual rate cells in rural states and some populations, yet ensures that expenditures remain budget neutral for each region and State.
2. ☒ The State has chosen not to make adjustment.
3. _____ Other (please describe):

j. Retrospective Eligibility (Appendix D.III, Line 60): States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCOs/PHPs will not incur costs associated with retrospective eligibility because capitated eligibility is prospective. Please note, however, that newborns need not be removed from the base year costs if the State provides retrospective eligibility back to birth for newborns.

Basis and Methodology:

1. _____ Compare the date that the enrollee was determined Medicaid-eligible by the State to the date at which Medicaid-eligibility became effective. If the effective date is earlier than the eligibility date, then the costs for retrospective eligibility were removed.
2. ☒ The State has chosen not to make adjustment because it was not necessary given the State's enrollment process.
3. _____ Other (please describe):

k. Utilization (Appendix D.III, Line 62): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

1. _____ The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments made were service-specific and expressed as percentage factors.
2. ☒ The State has chosen not to make adjustment.
3. _____ Other (please describe):

l. Other Adjustments including but not limited to guaranteed eligibility and risk-adjustment (Appendix D.III, Line 63). If the State enrolls persons with special health care needs, please explain by population any payment methodology adjustments made by the State for each population. For example, HCFA expects States to set rates for each eligibility category (i.e., the State should set UPLs and rates separately for TANF, SSI, and Foster Care Children). Please list and describe the basis and methodology:

Step 9: With Waiver Cost Adjustments (in addition to the Capitated or FFS Base Year Cost Adjustments), Appendix D.III, Lines 70-72). Note: Costs for the following adjustments are included in the With Waiver Costs Appendix D.V.

a. Reinsurance or Stop/Loss Coverage (Appendix D.III, Line 71): Please note

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whether or not the State will be providing reinsurance or stop/loss coverage.

Reinsurance may be provided by States to MCOs/PHPs when MCOs/PHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PHP will be responsible. If the State plans to implement either reinsurance or stop/loss, a description of the methodology used is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The rate of expenses per capita should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in with waiver costs.

Basis and Methodology:

1. x The State does not provide reinsurance or stop/loss for MCOs/PHPs, but requires MCOs/PHP to purchase such coverage privately. No adjustment was necessary.

2. The State provides reinsurance or stop/loss (please describe):

b. Incentive/bonus payments (Appendix D.III, Line 72): This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. The State must document the criteria for awarding the incentive payments, the methodology for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the MCOs/PHPs do not exceed the UPL. The costs associated with any bonus arrangements must be accounted for in Appendix D.V With Waiver costs.

Please describe the criteria for awarding incentive payments, the methodology for calculating bonus amounts, and the monitoring the State will have in place to ensure that total payments to MCOs/PHPs do not exceed the UPL:

None provided for this waiver period.

c. Other Adjustments (Please list and describe the basis and methodology):
Rebasing of inpatient hospital rates paid on a DRG basis – the total cost of rebasing is estimated through an analysis of historical psychiatric claims. This amount is converted to a rate increase by dividing by the number of Medicaid eligible persons in each region of the state.

IV. Without Waiver Development: Appendix D.IV

Purpose: To calculate without waiver costs on a PMPM basis.

NOTE: HCFA will measure the cost effectiveness of the waiver in the renewal based on this PMPM calculation and the actual enrollment under the waiver.

Please note that the data in this section for Waiver Years 1 and 2 should reflect

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the PMPM Without Waiver costs that were approved in the previous waiver in your renewal, plus any changes approved by the RO in the annual capitated rate approval. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Step 10: See instruction box.

Step 11: See instruction box. These rate cells must be identical to the rate cells used in Appendix D.II Member Months.

Steps 12-13: See instruction boxes.

Step 14: See instruction box. Adjustments expressed as percentages are applied to the base year amount by category of service.

Steps 15-16: See instruction boxes.

Step 17: See instruction box. Step 17 is designed to incorporate the cost of FFS wraparound services into the without waiver costs. To simplify presentation, the State may combine all wraparound services listed at Appendix D.III, presenting them as one base year amount per rate cell. The State may then combine all adjustment factors which affect a given rate cell, and apply the adjustments accordingly. This methodology will result in a subtotal of adjusted FFS costs applied to each rate cell. If the State prefers, individual FFS wraparound services may be calculated on Appendix D.IV, as illustrated with pharmacy services in the example (Columns Z-AF). If adjusted FFS costs are material, the State should be prepared to explain the adjustments upon request.

Step 18: See instruction box. These amounts represent the final PMPM amounts which will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations. States should have PMPM costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18.

V. With Waiver Development: Appendix D.V

Steps 19-29

The actuarial basis for the capitation rates for both MCOs and *PHPs* must be specified in the waiver application, and there must be a demonstration that payments to the contractor will be on an actuarially sound basis, in accordance with the regulations at 42 CFR 434.61. The capitation rates must be specified in the waiver application. Specifying the "actuarial basis" of the capitation rate means providing a description of the methodology the State uses to determine its capitation rate(s). Among the possible methods a State might use are: a percentage of the UPL; a budget-based rate (e.g., the MCO/PHP's cost); and the contractor's community rate

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with adjustments as appropriate (e.g., for the scope of services in the State's contract and the utilization characteristics of the Medicaid enrollees).

You may use other methods as well. If there are adjustments for stop-loss and reinsurance arrangements, the actuarial basis for these adjustments should be documented. The important things to remember are that the rate methodology must be specified and there must be a demonstration that the rates do not exceed the UPL.

Finally, as specified in 42 CFR 447.361, payments to contractors must be no more than the cost of providing those same services on a FFS basis, to an actuarially equivalent nonenrolled population group (i.e., no greater than the UPL).

With waiver costs are the sum of payments to capitated providers, FFS payments for managed care enrollees that are controlled or affected by managed care providers, and the costs to the State of implementing and maintaining the managed care program.

a. Please mark and complete the following assurances to HCFA:

1. x The State assures HCFA that the capitated rates will be equal to or less than the UPL based upon the following methodology. Please attach a description of the rate setting methodology and how the State will ensure that rates are less than the UPL if the State is not setting rates at a percent of UPL.

(a) Rates are set at a percent of UPL

(b) Negotiation (please describe):

(c) Experience-based (contractor/State's cost experience or encounter data) (please describe):

(d) Adjusted Community Rate (please describe):

(e) x Other (please describe): *Actuarial rates set at outset of program plus increases approved by the state legislature. Increases approved result in a rate that is significantly less than the UPL.*

2. x The rates were set in an actuarially sound manner. Please list the name, organizational affiliation of the actuary used, and actuarial attestation of the initial capitation rates.

Cost Effectiveness and Efficiency

The composite per eligible client upper payment limit is managed by the State at the statewide PHP level. The State is requesting that cost effectiveness be measured overall for all regions under the waiver and not within each region. This is consistent with prior waivers approved. This will allow the State to realign regional funding with better measures of need without violating overall cost effectiveness. This will occur according to a plan approved by the State's Legislature using established measures

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of service need. The realignment of regional funding incorporates a statewide PMPM rate that is a composite of the regional rates approved in the prior waiver. The attachment explains in detail how the regional rates approved in the prior waiver were incorporated into the composite rate used in the funding realignment.

Similarly, the state is combining the actuarially determined inpatient rate with the actuarially determined outpatient rate into a combined rate for all services provided under the waiver. This combined rate promotes integration of services and a broader continuum of care service delivery method.

In order to show cost effectiveness the State will compare costs under the waiver to the projected costs of the program absent the waiver. This will be done by comparing total costs using contracted rate increased by each Medicaid eligibility category (categorically needy, disabled and medically needy) multiplied by actual caseload to determine costs under the waiver.

These costs will be compared to the projected costs of the program without a waiver. These costs will be calculated by inflating the base rate by the yearly medical inflation rate from the Bureau of Labor Statistics and multiplying this rate by total actual caseload. This total would be compared to the costs with the waiver to determine cost effectiveness.

Appendix I includes the actuarial report. Also included are worksheets showing inflation, rate adjustments, projected changes in Medicaid eligible and the estimated state and federal fund savings for FY2001, FY2002, and FY2003 using the much of the same methodology the state has applied since its original waiver in 1993.

However, the state has made changes to the way the funds are distributed throughout the state in response to Legislative direction. This direction entails a four to six-year phase-in for the allocation of funds from the historical method to the prevalence method. The historical method uses the actuarially determined per member per month (PMPM) rates (as determined in 1992 for outpatient services and 1997 for inpatient services) increased periodically by the Legislature. These are the rates that were approved in the last waiver period. The prevalence method uses the historical method rates (the rates approved last waiver period) for 2001 to calculate a weighted average statewide rate (WASR) for each category of Medicaid eligible. The WASR for each category is calculated by adding the PHP's inpatient and outpatient rates to create one rate. This is done by multiplying each PHP's rate by the number of Medicaid enrollees residing in that PHP, adding the results of all the categories to be combined, and dividing the sum by the state-wide number of Medicaid eligibles.

3. x The State will submit all capitated rates to the HCFA RO for prior approval.

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b. _____ The State is requesting a 1915(b)(3) waiver in section A.II.g.2 and will be providing non-state plan medical services.

1. _____ The State will be spending a portion of its savings above the capitation rates for additional services under the waiver.

Please state the actual amounts spent on 1915(b)(3) savings which was spent on additional services in the previous waiver period _____. This amount must be built into the State's with waiver costs for Years 1 and 2.

Please state the PMPM or aggregate amount of 1915(b)(3) savings which will be spent on additional services in the upcoming waiver period _____. This amount must be built into the State's with waiver costs for Years 3 and 4.

2. _____ The State is requiring plans to spend a portion of their capitated rate on additional non-State plan medical services.

Please state the actual amount or percent of the PMPM that was spent on average on non-State plan covered medical services _____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please document the actual amount spent on non-State plan medical services.

Please estimate the amount or percent of the PMPMs that will be spent on average on non-State plan covered medical services _____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please explain the assumptions that the State used to calculate this amount.

Steps 19-20: See instruction boxes. The eligibility categories and rate cells must agree with those in Appendix D.IV. States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. **Please note that the data in this section for Waiver Years 1 and 2 should reflect the actual costs incurred in the previous waiver period under the Waiver Program. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.** Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Steps 21-29: See instruction boxes.

VI. Year 1 Aggregate Costs: Appendix D.VI
See Instructions for C.VII Year 2 Aggregate Costs

VII. Year 2 Aggregate Costs: Appendix D.VII
Steps 30-35: See instruction boxes.

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VIII. Year 3 Aggregate Costs: Appendix D.VIII

See Instructions for C.VII Year 2 Aggregate Costs

IX. Year 4 Aggregate Costs: Appendix D.IX

See Instructions for C.VII Year 2 Aggregate Costs

X. Cost Effectiveness Summary: Appendix D.X

Steps 36-40: See instruction boxes.

Appendix D

Summary

	Year One	Year Two	Previous Waiver Period Total	Year Three	Year Four	Upcoming Waiver Period Total
Program Cost						
<i>Capitation Program:</i>						
<i>Without Waiver Cost</i>						
Chelan Douglas	\$ 3,756,347		\$ 4,006,343	\$ 4,258,316	\$ 8,264,659	
Clark	\$ 16,357,093		\$ 17,453,898	\$ 18,570,616	\$ 36,024,514	
Grays Harbor	\$ 4,468,305		\$ 4,768,516	\$ 5,073,429	\$ 9,841,945	
Greater Columbia	\$ 35,403,181		\$ 38,761,799	\$ 41,206,498	\$ 79,968,295	
King	\$ 70,012,482		\$ 74,750,950	\$ 79,506,972	\$ 154,257,921	
NEWRSN	\$ 4,887,390		\$ 5,212,322	\$ 5,544,016	\$ 10,756,338	
North Central	\$ 8,472,272		\$ 9,041,800	\$ 9,625,983	\$ 18,667,783	
North Sound	\$ 45,698,130		\$ 48,713,133	\$ 51,769,180	\$ 100,482,313	
Peninsula	\$ 15,030,062		\$ 16,035,690	\$ 17,057,408	\$ 33,093,098	
Pierce	\$ 42,368,690		\$ 45,199,868	\$ 48,062,328	\$ 93,262,196	
Southwest	\$ 3,954,760		\$ 4,219,455	\$ 4,486,373	\$ 8,705,828	
Spokane	\$ 14,636,586		\$ 15,583,922	\$ 16,552,585	\$ 32,136,507	
Thurston	\$ 10,389,967		\$ 11,083,640	\$ 11,783,242	\$ 22,866,882	
Timberlands	\$ 3,178,336		\$ 3,389,426	\$ 3,604,198	\$ 6,993,624	
Total Non-waiver Costs	\$ 279,613,600		\$ 298,220,760	\$ 317,101,144	\$ 615,321,904	
<i>Waiver Cost:</i>						
<i>Capitation Payments</i>						
Chelan Douglas	\$ 3,627,713		\$ 3,739,660	\$ 3,841,440	\$ 7,581,100	
Clark	\$ 13,997,516		\$ 14,432,479	\$ 14,834,003	\$ 29,266,482	
Grays Harbor	\$ 4,216,398		\$ 4,348,947	\$ 4,471,517	\$ 8,820,464	
Greater Columbia	\$ 30,709,956		\$ 31,613,877	\$ 32,473,962	\$ 64,087,838	
King	\$ 57,667,659		\$ 59,483,680	\$ 61,123,597	\$ 120,607,277	
NEWRSN	\$ 4,587,317		\$ 4,729,748	\$ 4,860,939	\$ 9,590,687	
North Central	\$ 7,692,425		\$ 7,937,679	\$ 8,165,559	\$ 16,103,238	
North Sound	\$ 37,295,610		\$ 38,415,028	\$ 39,446,566	\$ 77,861,594	
Peninsula	\$ 13,028,793		\$ 13,434,391	\$ 13,805,630	\$ 27,240,021	
Pierce	\$ 34,713,374		\$ 35,781,348	\$ 36,759,607	\$ 72,540,955	
Southwest	\$ 3,913,525		\$ 4,036,012	\$ 4,147,257	\$ 8,183,259	
Spokane	\$ 14,024,967		\$ 14,432,265	\$ 14,817,264	\$ 29,249,529	
Thurston	\$ 9,265,083		\$ 9,550,878	\$ 9,810,641	\$ 19,361,519	
Timberlands	\$ 3,266,325		\$ 3,367,711	\$ 3,460,684	\$ 6,828,595	
Total Waiver Costs	\$ 238,006,662		\$ 245,303,701	\$ 252,018,966	\$ 497,322,568	
Capitation Savings (Program Costs)	\$ 41,606,938		\$ 52,917,058	\$ 65,082,278	\$ 117,999,336	
Administrative Costs:						
<i>Direct Administrative Cost:</i>						
Children's Survey	\$ 200,000		\$ 200,000	\$ 200,000	\$ 200,000	
Adult's Survey			\$ 300,000		\$ 300,000	
Actuary				\$ 300,000	\$ 300,000	
Total Direct Administrative Costs	\$ 200,000		\$ 500,000	\$ 500,000	\$ 500,000	
<i>Indirect Administrative Costs:</i>						
MMIS Expense			\$ 25,000	\$ 25,000	\$ 50,000	
Total Indirect Administrative Costs			\$ 25,000	\$ 25,000	\$ 50,000	
Total Administrative Costs	\$ 200,000		\$ 525,000	\$ 525,000	\$ 550,000	
Total Savings	\$ 41,406,938		\$ 52,392,058	\$ 64,557,278	\$ 117,449,336	

FY02 OUTPATIENT PHP RATES WITH ADMINISTRATION & ASSUMED SAVINGS

	Children				Adults			
	Cat Needy	Disabled	Mod Needy	Expansion	Cat Needy	Disabled	Mod Needy	
Chelan Douglas	4.81	42.48	2.17	9.51	9.03	83.80	1.81	
Clark	10.18	105.52	1.19	9.51	3.91	101.27	5.05	
Grays Harbor	11.08	73.34	0.47	9.51	2.13	63.90	7.38	
Greater Columbia	13.53	52.27	12.89	9.51	6.54	81.18	9.04	
King	8.52	47.83	8.88	9.51	7.43	103.64	18.05	
NEWRSN	11.56	64.30	8.02	9.51	6.08	77.18	10.13	
North Central	11.03	44.55	4.45	9.51	7.28	82.00	74.47	
North Sound	14.63	40.95	8.12	9.51	12.80	110.88	9.37	
Peninsula	10.80	37.54	8.59	9.51	8.16	95.02	4.85	
Pierce	12.40	34.40	14.98	9.51	8.06	101.96	8.06	
Southwest	5.38	22.44	7.46	9.51	4.29	57.76	2.39	
Spokane	10.32	25.18	5.77	9.51	6.45	28.49	1.80	
Thurston Mason	7.74	64.54	10.02	9.51	9.52	71.52	10.18	
Timberlands	8.00	20.67	7.61	9.51	4.80	37.18	9.08	

FY87 INPATIENT GROSS CAPITATION

	Children		Adults	
	Non-Dis	Disabled	Non-Dis	Disabled
	3.83	22.03	4.38	17.00
	4.02	22.08	4.08	19.80
	2.85	24.70	2.64	15.28
	3.29	26.38	3.53	12.03
	2.84	22.05	4.73	22.79
	4.85	22.42	2.86	13.58
	4.25	20.47	3.81	18.53
	2.64	24.13	2.27	13.10
	2.71	21.40	2.88	13.20
	1.53	19.87	6.07	23.04
	3.61	24.31	3.93	20.86
	5.66	22.44	3.02	12.67
	4.78	22.50	3.15	19.01
	2.24	22.97	2.44	14.36

Conversion of Rates to Outpatient Gross Capitation

Formula: Rates/1.05 to factor out administration then/.99 for assumed savings

Chelan Douglas	4.63	40.85	2.09	9.15	8.69	80.62	1.74
Clark	9.77	101.51	1.14	9.15	3.70	97.42	4.80
Grays Harbor	10.66	70.55	0.22	9.15	2.05	61.47	7.10
Greater Columbia	13.02	50.28	12.40	9.15	6.20	78.10	8.70
King	8.20	46.01	8.52	9.15	7.15	90.70	17.94
NEWRSN	11.12	61.86	8.29	9.15	5.85	74.25	15.52
North Central	10.01	42.86	4.28	9.15	0.98	59.64	71.84
North Sound	14.07	48.05	7.81	9.15	12.31	106.67	9.01
Peninsula	10.20	38.11	8.20	9.15	5.93	91.41	4.67
Pierce	11.99	33.09	14.41	9.15	7.75	98.09	7.75
Southwest	5.18	21.59	7.18	9.15	4.13	55.57	2.30
Spokane	9.93	24.22	5.55	9.15	0.20	27.41	1.73
Thurston Mason	7.45	62.09	15.41	9.15	0.16	68.80	18.45
Timberlands	5.77	19.88	7.32	9.15	4.62	35.75	8.73

Actuary Recommended Adjustment

FY93	4.50%	104.50% FY93 - 1993 CPI Services
FY94	3.00%	107.64% FY94 - 1994 CPI Services
FY95	3.90%	111.84% FY 95 - FY 00
FY96	3.00%	115.20% Department of Labor - Bureau of Labor Statistics
FY97	2.80%	118.43% CPI for Medical Care - Unadjusted 12-month increase
FY98	3.40%	122.46% December to December
FY99	3.70%	126.99%
FY00	4.20%	132.32%
FY01	3.50%	138.95% Estimate - average of 95-00
FY 02	3.50%	141.74% Estimate - average of 95-00
FY 03	3.50%	146.70% Estimate - average of 95-00
APPLIED RATE	140.70%	

	FY03 Contracted Rates								FY03 Contracted Rates			
	Cat Needy	Children			Expansion	Adults			Non-Dis	Children		
		Disabled	Mod Needy			Disabled	Med Needy			Disabled	Non-Dis	Adults Disabled
Chelan Douglas	0.44	52.29	2.64	12.59	11.05	126.13	2.52		4.07	23.36	4.62	18.02
Clark	12.45	120.73	11.90	12.59	4.84	127.22	0.65		4.26	23.40	4.33	20.98
Grays Harbor	13.28	83.74	11.90	12.59	2.73	96.49	9.02		3.03	26.19	2.80	16.20
Greater Columbia	15.28	59.77	15.72	12.59	7.96	107.41	10.92		3.50	27.07	3.74	12.76
King	10.81	57.83	10.80	12.59	8.87	121.22	24.44		3.02	23.37	5.01	24.16
NEWRSN	13.28	73.60	11.00	12.59	7.41	118.38	21.30		5.14	23.76	3.04	14.39
North Central	13.28	54.60	11.90	12.59	8.80	91.20	98.78		4.50	21.70	4.04	17.52
North Sound	16.52	57.11	11.90	12.59	15.01	132.20	12.29		2.80	25.58	2.40	13.89
Peninsula	12.95	46.67	10.47	12.59	7.54	120.74	6.11		2.86	22.43	3.05	13.98
Pierce	14.08	42.93	11.90	12.59	9.84	121.76	10.63		1.02	21.07	6.44	25.38
Southwest	7.08	29.58	9.09	12.59	5.31	88.29	3.01		3.83	25.77	4.16	22.12
Spokane	12.63	32.64	11.90	12.59	7.88	48.56	2.50		5.99	23.78	3.84	13.43
Thurston Mason	9.74	73.81	11.90	12.59	11.64	95.84	25.45		5.05	23.86	3.34	20.14
Timberlands	7.78	27.57	9.28	12.59	5.91	64.69	11.18		2.37	24.35	2.58	15.21

Conversion of Rates to Service Costs

Formula: Rates/1.05 for administration in outpatient. Rates/1.025 for administration for inpatient

Chelan Douglas	6.13	49.80	2.51	11.99	10.52	120.12	2.40	3.97	22.79	4.51	17.58
Clark	11.86	114.98	11.33	11.99	4.61	121.16	6.33	4.16	22.83	4.22	20.47
Grays Harbor	12.65	79.75	11.33	11.99	2.60	91.90	8.59	2.90	25.55	2.73	15.80
Greater Columbia	14.55	56.92	14.97	11.99	7.58	102.30	10.40	3.41	27.29	3.65	12.45
King	10.10	55.08	10.29	11.99	8.45	115.45	23.28	2.95	22.80	4.89	23.57
NEWRSN	12.05	70.10	11.33	11.99	7.06	112.74	20.29	5.01	23.18	2.97	14.04
North Central	12.65	52.00	11.33	11.99	8.44	86.86	04.08	4.39	21.17	3.94	17.09
North Sound	15.73	54.39	11.33	11.99	14.87	125.90	11.70	2.73	24.90	2.34	13.55
Peninsula	12.33	44.45	9.07	11.99	7.18	114.99	5.82	2.79	21.88	2.98	13.64
Pierce	13.41	40.89	11.33	11.99	9.37	115.06	10.12	1.58	20.56	0.28	24.76
Southwest	6.72	28.17	8.66	11.99	5.08	84.09	2.87	3.74	25.14	4.06	21.58
Spokane	12.03	31.09	11.33	11.99	7.50	46.25	2.38	5.84	23.20	3.75	13.10
Thurston Mason	9.28	70.30	11.33	11.99	11.09	91.28	24.24	4.93	23.28	3.28	19.65
Timberlands	7.41	26.26	8.64	11.99	5.63	61.61	10.65	2.31	23.76	2.52	14.84

	FY02 Rates Inflated Forward								FY07 Rates Inflated Forward							
	Cal Needy	Children		Med Needy	Expansion	Cal Needy	Adults		Non-Dis	Children		Non-Dis	Adults			
		Disabled					Disabled	Med Needy		Disabled			Disabled			
Chelan Douglas	6.78	59.92		3.00	13.42	12.74	118.20	2.55		5.62	32.32		6.40	24.94		
Clark	14.34	148.92		1.88	13.42	5.52	142.92	7.13		5.90	32.39		5.99	29.05		
Grays Harbor	15.64	103.50		9.13	13.42	3.01	90.18	10.42		4.18	38.23		3.87	22.42		
Greater Columbia	19.09	73.77		18.19	13.42	9.23	114.57	12.76		4.83	38.70		5.18	17.85		
King	12.02	67.50		12.50	13.42	10.40	146.26	28.32		4.17	32.35		8.94	33.43		
NEWRSN	10.31	90.74		12.17	13.42	8.58	108.92	22.76		7.11	32.89		4.20	19.92		
North Central	15.57	62.87		8.28	13.42	10.25	87.50	105.10		6.23	30.03		5.59	24.25		
North Sound	20.65	70.49		11.46	13.42	18.06	158.48	13.22		3.87	35.40		3.33	19.22		
Peninsula	14.96	52.88		12.12	13.42	8.69	134.10	0.84		3.98	31.48		4.22	19.36		
Pierce	17.58	48.55		21.14	13.42	11.37	143.89	11.37		2.24	29.15		8.90	35.12		
Southwest	7.58	31.87		10.53	13.42	0.05	81.51	3.37		5.30	35.68		5.77	30.60		
Spokane	14.56	35.54		8.14	13.42	9.10	40.21	2.54		8.30	32.92		5.31	18.59		
Thurston Mason	10.92	91.08		22.61	13.42	13.44	100.93	27.07		0.98	33.01		4.82	27.89		
Timberlands	8.47	29.17		10.74	13.42	0.77	52.44	12.81		3.29	33.70		3.58	21.07		

FY02 OFFICIAL ESTIMATES OF MEDICAID ELIGIBLES- PER MONTH AVERAGES

Chelan Douglas	9,170	221	-	2,862	2,850	1,377	177		12,042	221	3,027	1,377				
Clark	24,071	838	-	5,978	10,331	5,306	279		30,648	838	10,810	5,306				
Grays Harbor	7,309	253	-	1,869	3,019	2,249	172		8,978	253	3,191	2,249				
Greater Columbia	88,380	1,900	-	15,581	23,108	10,317	1,070		83,081	1,900	24,178	10,317				
King	82,068	2,802	-	21,479	41,563	27,040	1,637		103,547	2,802	43,200	27,040				
NEWRSN	7,688	203	-	1,733	3,028	1,060	160		9,422	203	3,188	1,968				
North Central	17,514	472	-	4,439	5,337	2,971	331		21,953	472	5,668	2,071				
North Sound	51,450	1,754	-	10,863	21,232	13,201	925		68,113	1,754	22,157	13,201				
Peninsula	19,643	837	-	4,978	8,475	5,885	553		24,619	837	9,028	5,885				
Pierce	49,895	2,284	-	11,514	20,800	15,189	724		61,409	2,284	21,524	15,189				
Southwest	8,845	377	-	1,705	3,987	2,478	135		10,550	377	4,122	2,478				
Spokane	34,191	1,404	-	8,578	15,781	9,939	644		42,769	1,404	16,424	9,939				
Thurston Mason	18,601	706	-	4,350	6,884	4,614	270		20,958	706	7,134	4,614				
Timberlands	8,871	321	-	2,292	3,639	2,324	215		11,263	321	3,853	2,324				
	408,406	14,379	-	103,825	170,014	104,856	7,290		510,232	14,379	177,304	104,856	808,771			

FY02 INFLATED RATES PROJECTION

Chelan Douglas	747,728	159,151	-	401,001	435,843	1,954,470	5,417		811,896	85,836	232,316	412,153				
Clark	4,244,834	1,497,983	-	962,750	864,099	9,100,427	23,873		2,188,935	325,834	762,088	1,849,570				
Grays Harbor	1,371,505	313,729	-	286,800	108,898	2,433,705	21,509		450,453	109,834	148,209	604,944				
Greater Columbia	15,668,098	1,687,117	-	2,509,282	2,659,353	14,184,060	163,734		4,882,778	885,099	1,502,452	2,184,952				
King	11,841,324	2,269,700	-	3,459,255	5,229,802	47,458,821	517,034		5,176,872	1,087,880	3,597,154	10,848,217				
NEWRSN	1,605,121	221,462	-	278,167	311,789	2,569,760	43,608		804,413	80,269	160,495	470,015				
North Central	3,271,552	358,157	-	714,936	650,185	3,118,993	417,212		1,642,487	170,112	380,158	884,410				
North Sound	12,747,213	1,483,884	-	2,683,800	4,602,456	24,788,272	146,721		3,165,509	745,044	885,407	3,044,310				
Peninsula	3,628,182	532,335	-	801,370	884,098	9,469,300	45,400		1,174,496	318,333	457,694	1,367,418				
Pierce	10,528,388	1,330,518	-	1,854,420	2,839,188	20,226,924	98,813		1,654,008	798,886	2,209,896	6,401,270				
Southwest	802,868	143,400	-	274,604	289,840	2,423,884	5,472		870,452	161,487	285,188	909,962				
Spokane	5,975,551	598,891	-	1,381,501	1,723,749	4,705,293	19,620		4,281,437	554,804	1,048,888	2,210,788				
Thurston Mason	2,178,076	771,752	-	701,588	1,108,840	5,587,919	87,822		1,756,143	279,670	395,624	1,543,936				
Timberlands	911,529	112,280	-	369,091	295,780	1,482,787	32,991		444,118	129,879	185,512	587,598				
	75,317,965	11,478,119	-	16,721,350	21,727,511	155,574,600	1,620,225		29,043,895	5,730,572	12,310,831	33,305,538	*****			

	FY03 Adjusted Rates							FY03 Adjusted Rates				
	Cat Needy	Children Disabled	Med Needy	Expansion	Cat Needy	Adults Disabled	Med Needy	Non-Dis	Children Disabled	Non-Dis	Adults Disabled	
Chelan Douglas	6.13	49.80	2.51	11.99	10.52	120.12	2.40	3.97	22.79	4.61	17.58	
Clark	11.88	114.08	11.33	11.99	4.61	121.10	6.33	4.16	22.83	4.22	20.47	
Grays Harbor	12.65	79.75	11.33	11.99	2.60	91.90	8.59	2.06	25.55	2.73	15.80	
Greater Columbia	14.55	56.92	14.97	11.99	7.58	102.30	10.40	3.41	27.20	3.65	12.45	
King	10.10	55.08	10.29	11.99	8.45	115.45	23.28	2.95	22.60	4.69	23.57	
NEWRSN	12.05	70.10	11.33	11.99	7.06	112.74	20.29	5.01	23.18	2.97	14.04	
North Central	12.05	52.00	11.33	11.99	8.44	88.60	94.08	4.39	21.17	3.94	17.09	
North Sound	15.73	54.39	11.33	11.99	14.87	125.90	11.70	2.73	24.96	2.34	13.55	
Peninsula	12.33	44.45	9.97	11.99	7.18	114.99	5.82	2.79	21.88	2.98	13.64	
Pierce	13.41	40.89	11.33	11.99	9.37	115.00	10.12	1.58	20.56	0.28	24.70	
Southwest	6.72	28.17	8.66	11.99	5.06	84.09	2.87	3.74	25.14	4.06	21.58	
Spokane	12.03	31.09	11.33	11.99	7.50	46.25	2.38	5.84	23.20	3.76	13.10	
Thurston Mason	9.28	70.30	11.33	11.99	11.00	91.28	24.24	4.93	23.28	3.26	19.65	
Timberlands	7.41	26.26	8.84	11.99	5.63	61.61	10.65	2.31	23.76	2.52	14.84	

FY03 OFFICIAL ESTIMATES OF MEDICAID ELIGIBLES- PER MONTH AVERAGES

Chelan Douglas	0,179	221	-	2,862	2,650	1,377	177	12,042	221	3,027	1,377	
Clark	24,071	838	-	5,978	10,331	5,308	279	30,648	838	10,610	5,308	
Grays Harbor	7,309	253	-	1,669	3,010	2,240	172	8,978	253	3,191	2,249	
Greater Columbia	68,380	1,906	-	15,581	23,108	10,317	1,070	83,001	1,906	24,178	10,317	
King	82,068	2,802	-	21,479	41,563	27,040	1,637	103,547	2,802	43,200	27,040	
NEWRSN	7,688	203	-	1,733	3,028	1,968	160	8,422	203	3,188	1,968	
North Central	17,514	472	-	4,439	5,337	2,871	331	21,953	472	5,608	2,971	
North Sound	51,450	1,754	-	16,683	21,232	13,201	925	68,113	1,754	22,157	13,201	
Peninsula	19,643	837	-	4,976	8,475	5,885	553	24,619	837	9,028	5,885	
Pierce	49,895	2,284	-	11,514	20,800	15,189	724	61,409	2,284	21,524	15,189	
Southwest	8,645	377	-	1,705	3,987	2,478	135	10,550	377	4,122	2,478	
Spokane	34,181	1,404	-	8,578	15,781	9,939	644	42,769	1,404	10,424	9,939	
Thurston Mason	16,601	708	-	4,356	6,864	4,614	270	20,958	708	7,134	4,614	
Timberlands	8,971	321	-	2,292	3,639	2,324	215	11,263	321	3,853	2,324	
	406,400	14,379	-	103,825	170,014	104,856	7,290	510,232	14,379	177,304	104,856	806,771

FY03 ADJUSTED RATES PROJECTION

Chelan Douglas	875,599	132,268	-	411,803	350,923	1,985,219	5,089	573,776	60,530	163,712	290,543	
Clark	3,510,278	1,156,825	-	860,130	571,469	7,715,098	21,215	1,528,538	229,646	537,872	1,303,338	
Grays Harbor	1,109,330	241,742	-	240,153	94,189	2,480,016	17,741	318,488	77,450	104,602	420,533	
Greater Columbia	11,941,171	1,301,910	-	2,241,615	2,102,183	12,664,892	133,474	3,440,350	824,182	1,058,628	1,541,249	
King	9,851,330	1,851,938	-	3,090,520	4,213,327	37,460,097	457,242	3,661,020	706,650	2,533,854	7,648,160	
NEWRSN	1,108,854	171,069	-	249,410	258,437	2,059,937	38,801	566,952	58,573	113,453	331,222	
North Central	2,658,182	294,572	-	638,730	540,425	3,090,154	373,405	1,156,589	119,029	268,081	609,205	
North Sound	9,713,731	1,144,788	-	2,397,552	3,787,808	19,944,784	129,871	2,232,769	525,258	622,550	2,148,872	
Peninsula	2,807,192	446,815	-	715,951	730,289	8,120,057	38,598	824,317	219,882	322,351	983,120	
Pierce	8,028,817	1,120,542	-	1,658,756	2,339,140	21,138,218	87,048	1,164,681	563,375	1,022,820	4,513,140	
Southwest	713,654	127,565	-	245,333	241,937	2,500,353	4,650	473,048	113,845	200,747	641,712	
Spokane	4,935,222	523,899	-	1,234,245	1,421,168	5,515,774	18,390	2,999,249	390,998	738,376	1,502,877	
Thurston Mason	1,847,979	595,620	-	620,787	813,119	5,053,293	78,641	1,239,054	187,238	278,975	1,087,809	
Timberlands	797,634	101,047	-	329,749	245,770	1,718,469	27,413	312,495	91,422	116,388	413,904	
	59,856,854	9,210,179	-	14,929,004	17,817,181	132,050,370	1,432,596	20,491,305	4,036,890	6,682,407	23,479,383	#####

Appendix I



Milliman USA

Consultants and Actuaries

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July 16, 2001

Susan Lucas
Chief of Finance
Washington Dept. of Social & Health Services
Mental Health Division
P.O. Box 45320
Olympia, WA 98504-5320

Re: 2001-2003 RSN Payment Rates

Dear Susan:

Per your request, we have reviewed your "Step by Step Process" for the development of 2001-2003 RSN Payment Rates. We have found that your model accurately calculates the composite rates for Children and Adults separately for the Disabled and the Non-Disabled.

The model begins with rates cells split Children and Adults; outpatient categories Disabled, Categorically Needy, Medically Needy and Expansion; inpatient categories Disabled and Non-Disabled; and 14 geographic areas. In addition to rates for each cell, eligibility forecasts for 2002 were provided for each rate cell. We have relied on these rate and eligibility figures without audit in our analysis.

We have reviewed the calculations of the composite rates based on these starting assumptions and find the logic to be sound and the application to be accurate.

Please let me know if you have any additional questions.

Sincerely,

Timothy S. Barclay, FSA, MAAA
Consulting Actuary

/kcp

Washington State Mental Health Division
Development of 2001 - 2003 RSN Payment Rates
A step by step process

Step 1. Rates approved in the 1999 - 2001 Waiver

Outpatient	Children				Adults		
	Cal Needy	Disabled	Med Needy	Expansion	Cal Needy	Disabled	Med Needy
Chelan Douglas	6.44	52.29	7.64	12.59	11.05	126.13	2.52
Clark	12.45	120.73	11.90	12.59	4.84	127.22	0.55
Grays Harbor	13.28	83.74	11.90	12.59	2.73	95.49	0.02
Greater Columbia	15.28	59.77	15.22	12.59	7.88	107.41	10.92
King	10.61	57.83	10.80	12.59	8.87	121.22	24.44
NEWRSN	13.28	73.60	11.90	12.59	7.41	118.38	21.30
North Central	13.28	54.60	11.90	12.59	8.66	91.20	98.78
North Sound	16.52	57.11	11.90	12.59	15.61	132.20	12.29
Peninsula	12.95	48.67	10.47	12.59	7.54	120.74	6.11
Pierce	14.08	42.93	11.00	12.59	9.84	121.76	10.63
Southwest	7.06	28.58	9.09	12.59	5.31	88.28	3.01
Spokane	12.63	32.64	11.90	12.59	7.88	48.56	2.50
Thurston Mason	9.74	73.61	11.90	12.59	11.64	95.84	25.45
Timberlands	7.78	27.57	9.28	12.59	5.91	64.69	11.18
Statewide Average	12.01	56.04	0.00	12.59	9.17	110.19	17.20

Inpatient	Children		Adults	
	Non Disabled	Disabled	Non Disabled	Disabled
Chelan Douglas	4.07	21.36	4.62	18.17
Clark	4.26	23.40	4.33	22.09
Grays Harbor	3.03	26.19	2.80	16.86
Greater Columbia	3.50	22.97	3.74	12.82
King	3.02	23.37	5.01	24.19
Northeast (NEWRSN)	3.14	23.76	3.04	14.57
North Central	4.50	21.70	4.04	17.78
North Sound	2.80	25.58	2.40	13.95
Peninsula	2.86	22.43	3.05	14.43
Pierce	1.62	21.07	6.44	25.52
Southwest	3.83	25.77	4.16	24.21
Spokane	5.99	23.78	3.84	13.46
Thurston Mason	5.05	23.65	3.34	20.65
Timberlands	2.37	24.35	2.58	16.18
Statewide Average	3.43	23.98	4.18	19.37

Step 2. Med.aid Eligibles forecasted for fiscal year 2002.

* adjusted for an increase in imputed rates paid + 1.1% DRG basis

	CHILDREN				ADULTS				Total		KIDS		ADULTS	
	CN	DIS	MIN	EXP	CN	DIS	MIN	Total			NON DIS	DIS	NON DIS	DIS
Chelan Douglas	8,941	215	-	2,768	2,817	1,339	166	10,247	11,709	215	2,094	1,339		
Clark	24,031	815	-	5,780	10,212	5,158	263	48,259	29,812	815	10,475	5,158		
Grays Harbor	7,120	245	-	1,614	2,984	2,109	162	14,312	8,734	245	3,146	2,109		
Greater Columbia	68,608	1,852	-	15,066	22,843	10,030	1,008	117,404	81,674	1,852	23,848	10,030		
King	79,941	2,723	-	20,769	41,082	20,780	1,542	172,344	100,710	2,723	42,625	20,780		
NEWRSN	7,489	198	-	1,676	2,993	1,911	150	14,417	9,165	198	3,143	1,911		
North Central	17,060	459	-	4,292	5,275	2,688	312	30,286	21,353	459	5,587	2,688		
North Sound	50,117	1,704	-	16,112	20,866	12,833	871	102,624	66,229	1,704	21,858	12,833		
Peninsula	18,134	814	-	4,811	8,377	5,721	521	39,377	23,946	814	8,898	5,721		
Pierce	48,802	2,219	-	11,134	20,560	14,765	682	97,963	59,736	2,219	21,742	14,765		
Southwest	8,616	367	-	1,649	3,041	2,409	127	17,108	10,264	367	4,068	2,409		
Spokane	33,305	1,365	-	8,294	15,598	9,662	606	68,831	41,593	1,365	10,205	9,662		
Thurston Mason	16,171	686	-	4,212	6,785	4,485	235	32,594	20,383	686	7,039	4,485		
Timberlands	8,731	312	-	2,216	3,597	2,260	202	17,374	10,954	312	3,793	2,260		
Statewide Average	395,875	13,973	-	100,394	168,048	101,932	8,858	787,050	496,268	13,973	174,916	101,932		

Step 3. Combine Outpatient Non-Disabled categories into one rate.
Revenue for non-disabled outpatient categories:

	Children				Adult		
	CN	MIN	Expansion	TOTAL	CN	MIN	TOTAL
Chelan Douglas	690,997	-	418,101	1,109,158	373,547	5,035	378,582
Clark	3,590,280	-	873,280	4,463,563	593,101	20,987	614,088
Grays Harbor	1,134,813	-	743,826	1,878,639	97,754	17,550	115,304
Greater Columbia	12,213,321	-	2,276,097	14,489,418	2,181,758	132,039	2,313,797
King	10,178,130	-	3,137,760	13,315,890	4,372,815	452,324	4,825,139
NEWRSN	1,183,448	-	253,224	1,436,672	268,144	38,443	306,587
North Central	2,718,744	-	648,418	3,367,161	560,881	359,448	920,329
North Sound	9,935,115	-	2,434,213	12,369,328	3,931,188	128,474	4,059,662
Peninsula	2,973,449	-	726,900	3,700,349	757,933	38,182	796,115
Pierce	8,211,801	-	1,682,091	9,893,892	2,427,871	87,000	2,514,871
Southwest	729,919	-	249,085	979,004	255,095	4,600	259,695
Spokane	5,047,700	-	1,253,119	6,300,819	1,474,054	18,192	1,492,246
Thurston Mason	1,890,096	-	636,372	2,526,468	947,684	77,795	1,025,479
Timberlands	815,813	-	334,792	1,150,605	255,073	27,118	282,191

Medicaid Eligibles for non-disabled categories

	Children				Adults		
	CN	MIN	Expansion	TOTAL	CN	MIN	TOTAL
Chelan Douglas	8,941	-	2,768	11,709	2,817	166	2,984
Clark	24,031	-	5,780	29,812	10,212	263	10,475
Grays Harbor	7,120	-	1,614	8,734	2,984	162	3,146
Greater Columbia	68,608	-	15,066	83,674	22,843	1,008	23,851
King	79,941	-	20,769	100,710	41,082	1,542	42,625
Northeast (NEWRSN)	7,489	-	1,676	9,165	2,993	150	3,143
North Central	17,060	-	4,292	21,353	5,275	312	5,587
North Sound	50,117	-	16,112	66,229	20,866	871	21,737
Peninsula	18,134	-	4,811	22,946	8,377	521	8,898
Pierce	48,802	-	11,134	59,936	20,560	682	21,242
Southwest	8,616	-	1,649	10,264	3,041	127	3,168
Spokane	33,305	-	8,294	41,599	15,598	606	16,205
Thurston Mason	16,171	-	4,212	20,383	6,785	235	7,020
Timberlands	8,731	-	2,216	10,947	3,597	202	3,799

Revenue / Eligibles for total of non-disabled categories equals non-disabled outpatient rate

	Children	Adults
Chelan Douglas	7.82	10.57
Clark	12.48	4.80
Grays Harbor	13.15	3.05
Greater Columbia	14.78	8.09
King	11.02	9.43
NEWRSH	13.15	8.07
North Central	13.14	13.88
North Sound	15.56	15.48
Peninsula	12.88	7.46
Pierce	13.80	9.87
Southwest	7.95	5.24
Spokane	12.62	7.68
Thurston Mason	10.33	12.14
Timberlands	8.75	6.19

Step 4: Combine Inpatient and Outpatient Rates into one combined rate.

	Outpatient		Inpatient		Combined	
	Children	Adults	Children	Adults	Children	Adults
	Non-Disabled	Disabled	Non-Disabled	Disabled	Non-Disabled	Disabled
Chelan Douglas	7.89	52.29	10.57	126.13	4.07	23.36
Clark	12.48	120.73	4.89	127.22	4.26	23.40
Grays Harbor	13.15	83.74	3.05	96.48	3.03	26.19
Greater Columbia	14.78	59.77	8.09	107.41	3.50	27.97
King	11.02	57.83	9.43	121.22	3.02	23.37
NEWRSH	13.15	73.60	8.07	118.39	5.14	23.76
North Central	13.14	54.60	13.88	91.20	4.50	21.70
North Sound	15.56	57.11	15.48	132.20	2.60	25.58
Peninsula	12.88	40.67	7.46	120.74	2.86	22.43
Pierce	13.80	42.83	9.87	121.76	1.62	21.07
Southwest	7.95	29.58	5.24	88.29	3.83	25.77
Spokane	12.62	32.64	7.68	48.56	5.99	23.78
Thurston Mason	10.33	73.81	12.14	95.84	5.05	23.86
Timberlands	8.75	27.57	6.19	64.69	2.37	24.35

Step 5: Create Statewide Weighted Average Rate using Combined Rates and Medicaid Eligibles Forecast

	Revenue using combined rates		Medicaid Eligibles	
	Children	Adults	Children	Adults
	Non-Disabled	Disabled	Non-Disabled	Disabled
Chelan Douglas	1,680,518	195,252	543,848	2,318,225
Clark	5,988,553	1,408,913	1,158,930	9,242,378
Grays Harbor	1,695,734	323,808	220,856	2,073,722
Greater Columbia	17,915,994	1,950,060	3,395,529	14,470,338
King	18,987,687	2,653,272	7,388,014	45,867,000
NEWRSH	2,011,556	230,002	419,088	3,048,188
North Central	4,518,901	420,025	1,201,447	3,778,507
North Sound	14,591,508	1,691,261	4,689,767	22,506,028
Peninsula	4,522,830	674,725	1,122,161	9,278,722
Pierce	11,053,518	1,704,511	4,157,423	28,090,416
Southwest	1,450,970	243,558	458,866	3,252,125
Spokane	9,289,871	924,024	2,240,121	7,100,922
Thurston Mason	3,761,962	804,207	1,307,641	6,269,563
Timberlands	1,481,748	184,187	359,782	2,192,875
Statewide	88,912,509	13,418,685	28,691,472	158,483,001

Weighted Average Rates	10.27	80.02	13.67	129.57
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Mental Health Division
Proposed RSN Funding Allocation Model
2001 - 2003 Biennium

Model uses combined outpatient and inpatient statewide average rates.

Combined Rates by Category:

	Children		Adults	
	Non-Disabled	Disabled	Non-Disabled	Disabled
Fiscal Year 2002	16.27	80.02	13.67	129.57
Fiscal Year 2003	16.27	80.02	13.67	129.57

Mental Health Division
Combined Model for Legislative Budget at New FMAP
1999-01

RSN Outpatient Rates for 01-03

FY 2001

	Children		Med		Adults		
	Cat Needy	Disabled	Needy	Expansion	Cat Needy	Disabled	Med Needy
Chelan Douglas	6.44	52.29	2.64	12.59	11.05	126.13	2.52
Clark	12.45	120.73	11.90	12.59	4.84	127.22	6.65
Grays Harbor	13.28	83.74	11.90	12.59	2.73	96.49	9.02
Greater Columbia	15.28	59.77	15.72	12.59	7.96	107.41	10.92
King	10.61	57.83	10.80	12.59	8.87	121.22	24.44
NEWRSN	13.28	73.60	11.90	12.59	7.41	118.38	21.30
North Central	13.28	54.60	11.90	12.59	8.86	91.20	98.78
North Sound	16.52	57.11	11.90	12.59	15.61	132.20	12.29
Peninsula	12.95	46.67	10.47	12.59	7.54	120.74	6.11
Pierce	14.08	42.93	11.90	12.59	9.84	121.76	10.63
Southwest	7.06	29.58	9.09	12.59	5.31	88.29	3.01
Spokane	12.63	32.64	11.90	12.59	7.88	48.56	2.50
Thurston Mason	9.74	73.81	11.90	12.59	11.64	95.84	25.45
Timberlands	7.78	27.57	9.28	12.59	5.91	64.69	11.18
Statewide Average	12.91	56.04	-	12.59	9.17	110.19	17.20

FY 2002

	Children		Med		Adults		
	Cat Needy	Disabled	Needy	Expansion	Cat Needy	Disabled	Med Needy
Chelan Douglas	6.44	52.29	2.64	12.59	11.05	126.13	2.52
Clark	12.45	120.73	11.90	12.59	4.84	127.22	6.65
Grays Harbor	13.28	83.74	11.90	12.59	2.73	96.49	9.02
Greater Columbia	15.28	59.77	15.72	12.59	7.96	107.41	10.92
King	10.61	57.83	10.80	12.59	8.87	121.22	24.44
NEWRSN	13.28	73.60	11.90	12.59	7.41	118.38	21.30
North Central	13.28	54.60	11.90	12.59	8.86	91.20	98.78
North Sound	16.52	57.11	11.90	12.59	15.61	132.20	12.29
Peninsula	12.95	46.67	10.47	12.59	7.54	120.74	6.11
Pierce	14.08	42.93	11.90	12.59	9.84	121.76	10.63
Southwest	7.06	29.58	9.09	12.59	5.31	88.29	3.01
Spokane	12.63	32.64	11.90	12.59	7.88	48.56	2.50
Thurston Mason	9.74	73.81	11.90	12.59	11.64	95.84	25.45
Timberlands	7.78	27.57	9.28	12.59	5.91	64.69	11.18
Statewide Average	12.91	56.04	-	12.59	9.17	110.19	17.20

FY 2003

	Children		Med		Adults		
	Cat Needy	Disabled	Needy	Expansion	Cat Needy	Disabled	Med Needy
Chelan Douglas	6.44	52.29	2.64	12.59	11.05	126.13	2.52
Clark	12.45	120.73	11.90	12.59	4.84	127.22	6.65
Grays Harbor	13.28	83.74	11.90	12.59	2.73	96.49	9.02
Greater Columbia	15.28	59.77	15.72	12.59	7.96	107.41	10.92
King	10.61	57.83	10.80	12.59	8.87	121.22	24.44
NEWRSN	13.28	73.60	11.90	12.59	7.41	118.38	21.30
North Central	13.28	54.60	11.90	12.59	8.86	91.20	98.78
North Sound	16.52	57.11	11.90	12.59	15.61	132.20	12.29
Peninsula	12.95	46.67	10.47	12.59	7.54	120.74	6.11
Pierce	14.08	42.93	11.90	12.59	9.84	121.76	10.63
Southwest	7.06	29.58	9.09	12.59	5.31	88.29	3.01
Spokane	12.63	32.64	11.90	12.59	7.88	48.56	2.50
Thurston Mason	9.74	73.81	11.90	12.59	11.64	95.84	25.45
Timberlands	7.78	27.57	9.28	12.59	5.91	64.69	11.18
Statewide Average	12.91	56.04	-	12.59	9.17	110.19	17.20

Mental Health Division
Combined Model for Legislative Budget at New FMAP
1999-01

RSN Inpatient Rates for 01-03

Fiscal Year 2001	Fiscal Year 2001			
	INPATIENT			
	Children		Adults	
	Non-Disabled	Disabled	Non-Disabled	Disabled
Chelan Douglas	4.07	23.36	4.62	18.02
Clark	4.26	23.40	4.33	20.98
Grays Harbor	3.03	26.19	2.80	16.20
Greater Columbia	3.50	27.97	3.74	12.76
King	3.02	23.37	5.01	24.16
Northeast (NEWRSN)	5.14	23.76	3.04	14.39
North Central	4.50	21.70	4.04	17.52
North Sound	2.80	25.58	2.40	13.89
Peninsula	2.86	22.43	3.05	13.98
Pierce	1.62	21.07	6.44	25.38
Southwest	3.83	25.77	4.16	22.12
Spokane	5.99	23.78	3.84	13.43
Thurston Mason	5.05	23.66	3.34	20.14
Timberlands	2.37	24.35	2.58	15.21
Statewide Average	3.43	23.98	4.18	19.13

Fiscal Year 2002	Fiscal Year 2002			
	INPATIENT			
	Children		Adults	
	Non-Disabled	Disabled	Non-Disabled	Disabled
Chelan Douglas	4.07	23.35	4.62	18.17
Clark	4.26	23.40	4.33	22.09
Grays Harbor	3.03	26.19	2.80	16.85
Greater Columbia	3.50	27.97	3.74	12.62
King	3.02	23.37	5.01	24.19
Northeast (NEWRSN)	5.14	23.76	3.04	14.52
North Central	4.50	21.70	4.04	17.76
North Sound	2.80	25.58	2.40	13.95
Peninsula	2.86	22.43	3.05	14.43
Pierce	1.62	21.07	6.44	25.52
Southwest	3.83	25.77	4.16	24.21
Spokane	5.99	23.78	3.84	13.46
Thurston Mason	5.05	23.66	3.34	20.65
Timberlands	2.37	24.35	2.58	16.18
Statewide Average	3.43	23.98	4.18	19.37

Fiscal Year 2003	Fiscal Year 2003			
	INPATIENT			
	Children		Adults	
	Non-Disabled	Disabled	Non-Disabled	Disabled
Chelan Douglas	4.07	23.36	4.62	18.17
Clark	4.26	23.40	4.33	22.09
Grays Harbor	3.03	26.19	2.80	16.85
Greater Columbia	3.50	27.97	3.74	12.82
King	3.02	23.37	5.01	24.19
Northeast (NEWRSN)	5.14	23.76	3.04	14.52
North Central	4.50	21.70	4.04	17.76
North Sound	2.80	25.58	2.40	13.95
Peninsula	2.86	22.43	3.05	14.43
Pierce	1.62	21.07	6.44	25.52
Southwest	3.83	25.77	4.16	24.21
Spokane	5.99	23.78	3.84	13.46
Thurston Mason	5.05	23.66	3.34	20.65
Timberlands	2.37	24.35	2.58	16.18
Statewide Average	3.43	23.98	4.18	19.37

MAA Rebased Allocation Based on FY00 data
(allocation is within disabled adults category)

	Total Claims	Total DRG Claims	DRG Claims % of Total	DRG Claims Total Claims	Allocation of Rebase	2001 Rate Effect
Chelan	263,575	3,084	0.18%	1,171%	2,352	0.11
Clark	484,268	165,499	9.85%	34.17%	68,675	1.11
Grays	355,712	34,046	2.03%	8.60%	17,291	1.88
Greater	2,663,605	105,929	6.32%	3.87%	7,183	0.13
King	10,193,512	466,844	29.05%	4.76%	9,599	0.10
North East	365,875	5,600	0.33%	1.53%	3,076	0.10
North Central	629,537	28,375	1.69%	4.51%	9,058	1.25
North Sound	3,938,547	172,665	10.30%	4.38%	8,811	1.06
Peninsula	556,544	91,043	5.43%	15.26%	30,672	3.45
Pierce	1,600,521	159,823	11.81%	12.47%	25,066	0.14
Southwest	466,695	146,574	9.75%	30.12%	60,526	2.09
Spokane	4,545,836	94,246	5.03%	1.85%	3,725	0.03
Thurston	840,542	115,445	8.89%	13.73%	27,503	0.51
Timberlands	280,341	36,772	2.19%	13.12%	26,360	0.97
	27,585,311	1,675,735	100.00%	149.27%	300,000	
					300,000	